IDAHO SKIN INSTITUTE MEDICAL HISTORY
History and Intake Form

Referring/Primary Care Physician:_____

NAME:_____**DATE OF BIRTH:**_____**DATE:**_____

REASON FOR TODAYS VISIT:_____

Past Medical History: (please circle all that apply)

Anxiety	Coronary Artery Disease	Hypothyroidism
Arthritis	Depression	Leukemia
Artificial joints	Diabetes	Lung Cancer
Asthma	End Stage Renal Disease	Lymphoma
Atrial fibrillation	GERD (Acid reflux)	Pacemaker
BPH (Benign Prostatic Hyperplasia)	Hearing Loss	Prostate Cancer
	Hepatitis	Radiation Treatment
Bone Marrow Transplantation	Hypertension	Seizures
Breast Cancer	HIV/AIDS	Stroke
Colon Cancer	Hypercholesterolemia	Valve Replacement
COPD (Emphysema)	Hyperthyroidism	None

Other _____

Past Surgical History: (please circle all that apply)

Appendix Removed	Coronary Artery Bypass	Prostate Removed: Prostate Cancer
Bladder Removed	PTCA	
Mastectomy (Right, Left, Bilateral)	Mechanical Valve Replacement	Prostate Biopsy
Lumpectomy (Right, Left, Bilateral)	Biological Valve Replacement	TURP
Breast Biopsy (Right, Left, Bilateral)	Heart Transplant	Skin Biopsy
Breast Reduction	Knee Replacement (Right, Left, Both))	Basal Cell Cancer Surgery
Breast Implants	Hip Replacement(Right, Left, Bilateral)	Squamous Cell Carcinoma Surgery
Colectomy: Colon Cancer Resection	Joint Replacement (within last 2years)	
	Kidney Biopsy	Melanoma Surgery
Colectomy: Diverticulitis	Kidney Removed (Right, Left)	Spleen Removed
Colectomy: IBD	Kidney Stone Removal	Testicles Removed (Right, Left, Both))
Gallbladder Removed	Kidney Transplant	None

Other _____

Skin Disease History: (please circle all that apply)

Acne	Poison Ivy	*Basal Cell Skin Cancer: Location:_____ Year:___
Actinic Keratoses	Precancerous Moles	
Asthma	Psoriasis	*Squamous Cell Skin Cancer: Location:_____ Year:___
Blistering Sunburns	Dry Skin	
Flaking or Itchy Scalp	Eczema	*Melanoma: Location:_____Year:___
Hay Fever/Allergies	None	

Other _____

Women ONLY: (please circle all that apply)

Currently Pregnant	Ovaries Removed:	Oral Contraception
Breast Feeding	Endometriosis	Tubal Ligation
Hysterectomy:	Ovarian Cancer	Post-Menopausal
Fibroids	Ovarian Cyst	Frequent Yeast Infections
Uterine Cancer		

Other _____

Are you currently experiencing any of the following? (Please check yes or no for the following)

Alert	Yes	No
Pacemaker/Defibrillator		
Pacemaker/Defibrillator- OK with magnet		
Artificial joint		
HIV		
Hepatitis B		
Hepatitis C		
Aspirin		
Coumadin		
Plavix		
Prophylactic antibiotics (antibiotics needed before dental work)		
Allergy to adhesive		
Allergy to topical antibiotics		
Bad reaction to Novacaine		
Large scars/keloids		
Immunosuppression		
Organ Transplant		
Pregnant		
Allergy to Latex		
Other		

Review of Symptom	Yes	No
Problem with bleeding		
Problem with healing		
Problem with scarring/ keloids		
Rash		
Immunosuppression		
Hay fever		
Chest pain		
Fever/chills		
Night sweats		
Unintentional Weight loss		
Thyroid problems		
Anxiety		
Depression		
Abdominal Pain		
Shortness of Breath		
Cough		
Joint aches		
Muscle weakness		
Headaches		
Seizures		
Anemia		
Other		

Do you wear Sunscreen? Yes No
If yes, what SPF? _____
Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? _____
Any other family history: _____

Medications: (Please enter all current medications)

_____
_____

Allergies: (Please enter all allergies)

_____
_____

Social History: (Please circle all that apply)

Cigarette Smoking:
Never smoked
Quit: former smoker
Smokes less than daily
Smokes daily

Alcohol Use:
YES
NO

Height: _____
Weight: _____

Pharmacy: Name: _____
Street: _____ Zip Code: _____